Office of the Healthcare Advocate
STATE OF CONNECTICUT

Testimony of the Office of the Healthcare Advocate
Before the Insurance and Real Estate Committee
Re HB 7123
March 2, 2017

Good afternoon, Senator Larson, Senator Kelly, Representative Scanlon, Representative Sampson, and members of the Insurance and Real Estate Committee. For the record, I am Ted Doolittle, Healthcare Advocate. The Office of the Healthcare Advocate ("OHA") is an independent state agency with a three-fold mission: assuring consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I appreciate the opportunity to comment on HB 7123, An Act Limiting Changes to Health Insurers' Prescription Drug Formularies. Under current law, health care insurers are free to add or remove drugs from their formularies, or shift individual drugs between coverage tiers, at any time during a plan year. When such changes occur in the middle of a plan year, consumers can be negatively impacted – through higher cost-shares or complete loss of coverage (unless they meet specific statutory criteria). Moreover, the unanticipated financial burden consumers face from these out-of-pocket expense increases can result in negative medical consequences. Consumers who cannot absorb the costs resulting from a formulary modification may choose to limit their doses in an attempt to make their supply last longer, or forego their medication altogether, thereby delaying or avoiding the additional expense, but jeopardizing their treatment.

HB 7123 offers remedies for these uncertainties by imposing reasonable limitations on what modifications are permissible, without foreclosing a carrier's ability to impose mid-year modifications to its formulary and tier structure. Specifically, HB 7123 will prohibit carriers only from: (1) removing safe and effective drugs from their formularies in the middle of a plan year; (2) shifting a safe and effective drug to a higher cost tier during a plan year.

Consumers who use medication for chronic conditions, or who otherwise are able to anticipate their consumption of pharmaceuticals over the course of a plan year, spend substantial time and energy reviewing and comparing plans and formularies in order to select and enroll in the coverage that best suits their individual health care and prescription drug needs. However, even the most diligent consumer will be unable to predict when, or in what manner, a particular plan may choose to amend its formulary during a plan year. HB 7123 presents a common-sense solution to this problem by ensuring that the insurance contract to which the consumer agrees, based on a specific formulary structure, cannot be unilaterally amended by the insurer – with no opportunity for the consumer to pursue a different agreement. Consumers can therefore be assured that they will receive the benefit of the pharmacy benefit for which they bargained based on information available to them at the time of enrollment.

Despite the limitations imposed by HB 7123, carriers will still have great flexibility to modify their prescription drug formularies in response to market conditions. New drugs may be added at any time to any tier level. In addition, drugs may be moved from higher tier levels to lower tiers. These permissible changes not only mitigate adverse and unexpected financial impact on consumers, but also permit the implementation of efficiencies and other financial benefits for the carriers as well.

Thank you very much for your commitment to this timely and important issue. If you have any questions concerning my testimony, please feel free to contact me at ted.doolittle@ct.gov.